I. INTRODUCTION AND SYNOPSIS

A. Introduction and Limitations on Analysis

The IRS commenced its Hospital Compliance Project (Project) in May 2006 to study nonprofit hospitals and community benefit, and to determine how nonprofit hospitals establish and report executive compensation. The Project involved mailing out a comprehensive compliance check questionnaire to 544 nonprofit hospitals and analyzing their responses.[1] The questionnaire (see Appendix B) requested information regarding the hospital's activities, governance, expenditures, and executive compensation practices. The Project also involved examinations of 20 hospitals regarding executive compensation issues.

The hospitals included in the study represent a modest portion of the nonprofit hospital sector. See Section III, below, for a discussion of background on U.S. hospitals and of other recent government reports on community benefit and executive compensation provided by nonprofit hospitals.

The IRS issued its Interim Report on Hospital Compliance Project on July 19, 2007 (Interim Report). The Interim Report addressed only the community benefit aspects of the questionnaire and presented data gathered from the questionnaire responses of 487 hospitals and certain information reported on Forms 990 filed by responding hospitals. The executive compensation component of the Project was not addressed in the Interim Report because the examinations were ongoing at the time of the report's release.

The Final Report addresses the "next steps" identified in the Interim Report. These are:

- Analyze the reported data to determine whether differences in reporting, such as the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons across the respondents.
- Obtain additional research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural and urban communities and hospitals.
- Test the reported community benefit amounts and types by conducting data analysis, compliance checks, or examinations of individual hospitals, and by other means, including with respect to outliers in the reported data.

[1] A copy of the questionnaire is attached as Appendix B. In selecting the hospitals to be contacted, the IRS queried its files to identify nonprofit hospitals exempt under section 501(c)(3). From an initial identified universe of approximately 6,000 entities, the IRS selected 544 organizations that it confirmed as hospitals. The IRS sent compliance questionnaire letters to each of these hospitals, which were of varying sizes and types and were located in different regions and communities across the United States. Some judgment was used to identify hospitals which were not uniquely identifiable in the IRS database. The resulting sample may or may not reflect the nonprofit hospital sector in general.

The IRS also indicated it would (1) follow up on the 11 hospitals that did not respond to the questionnaire; (2) continue its work on the Form 990, Schedule H, Hospitals;[2] and (3) complete the executive compensation component of the project.

The IRS continued to study the information provided by the responding hospitals, and obtained additional information regarding 11 hospitals that initially did not respond to the questionnaire. The numbers reported in the Interim Report have been adjusted in the Final Report to reflect this further study and additional information. Significant adjustments to the data reported in the Interim Report are listed in Section II, below. The Final Report includes 489 respondent hospitals that reported community benefit expenditures, but generally summarizes data for the 485 hospitals that actually provided sufficiently complete community benefit data. There are other situations in which certain respondents did not provide sufficient information to permit categorization of all of the indices/variables considered in this report. Sample sizes will vary as a result.

Throughout the report, certain information was not included or was combined with other information to prevent potential identification of respondent hospitals. In addition, because of rounding conventions, some figures may not reconcile (including that, in some cases, the combined data for individual categories of a group may be slightly more or less than 100%).

The findings of the Final Report are subject to a number of limitations. Except for certain compensation data that was reviewed through examinations, the data reported by the respondents was not independently verified. In addition, the data reported responds to a single tax year and may not be representative of results for a different tax year or on an ongoing basis. Results for a different year could vary significantly depending on a variety of factors, including, for example, the economic climate. It is also important to note that the percentage of hospitals included in the various categories used in the report (e.g., community type) may not be representative of the sector at large. This may have an effect on certain findings in the report.

The study found significant variations from community benefit reporting that will be required by the new Form 990 Schedule H beginning with 2009 tax years. The community benefit expenditures reported by some hospitals appear to overstate Form 990 reportable community benefit, due to reporting uncompensated care based on charges rather than on costs, or including bad debt, Medicare shortfalls, and private insurance shortfalls as community benefit. On the other hand, exclusion by some hospitals of shortfalls from Medicaid, other means-tested public programs, or uninsured patients as uncompensated care, may understate the Form 990 reportable community benefit attributable to those programs.

[2] See Appendix C for a copy of Form 990, Schedule H, released in official form on December 24, 2008.

For these and other reasons, the summarized community benefit data is subject to material limitations, and may not accurately depict the community benefit actually provided by the respondents or by nonprofit hospitals as a whole. Notwithstanding these limitations, some interesting findings are suggested in both the community benefit and compensation areas of the study.

B. Demographics and Key Findings

The hospitals were classified into four community types based on location of the hospital and in part on Census Bureau data: high population, other urban and suburban, critical access hospitals, and rural non-critical access hospitals. The 94 hospitals (19%) located in the 26 largest urban areas in the United States were categorized in the high population category. The other 249 hospitals (51%) located in Census Bureau urban areas were included in the other urban and suburban category. The 68 hospitals (14%) designated as critical access hospitals under federal law were categorized in the critical access hospital (CAH) category. The 78 hospitals (16%) that are not CAHs and not located in any Census Bureau urban area were categorized in the rural (non-CAH) category.

The hospitals also were classified by revenue size based on annual revenues as reported on Forms 990 as follows: (1) under $25 million, 85 hospitals (17%); (2) $25 million to $100 million, 173 hospitals (36%); (3) $100 million to $250 million, 133 hospitals (27%); (4) $250 million to $500 million, 61 hospitals (13%); and (5) over $500 million, 36 hospitals (7%). For purposes of this section, reporting of revenue size categories generally is limited to the smallest and largest categories, where the differences are most pronounced.

The hospitals also were categorized and examined based on health insurance coverage and per capita income of the area surrounding the hospital. In addition, a group of 15 hospitals reporting nearly all (93%) of the reported medical research expenditures was studied.

1. Diversity of nonprofit hospitals. There was considerable diversity in the demographics, activities, and financial resources among the respondent hospitals. The types and amounts of uncompensated care and other community benefit expenditures varied by the hospitals across revenue size, income and insurance coverage levels of the surrounding area, and the hospital's setting within a rural, suburban, or urban community. In particular, significant differences were observed between the groups of critical access hospitals and hospitals in the high population areas, and between the smallest and largest groups of hospitals based on revenue size (e.g., in general, larger hospitals reported higher community benefit expenditures and higher excess revenues).

2. Aggregate community benefit. The average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were 9% and 6%, respectively, for the overall group. Among the community types,

these percentages were lowest for rural hospitals (CAH and non-CAH) and highest for hospitals in the high population areas. These percentages generally increased with revenue size. For the group of 15 hospitals reporting disproportionately large medical research expenditures, the average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were both 19%.

3. Types of community benefit. Uncompensated care was the largest reported community benefit expenditure overall and across all demographics, other than for the group of 15 hospitals that reported nearly all of the aggregate medical research expenditures. Overall, the average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%, respectively. Reported uncompensated care expenditures were 56% of aggregate community benefit expenditures. Medical education and training expenditures constituted 23% of aggregate reported expenditures, followed by medical research (15%), and community programs (6%). This mix varied by community type and revenue size, and as described below, materially changed when the group of 15 hospitals reporting disproportionately large medical research expenditures was excluded.

4. Concentration of expenditures in small group of hospitals. Uncompensated care and aggregate community benefit expenditures were unevenly distributed among hospitals and concentrated in a relatively small group. The study looked at reported community benefit compared to certain specified revenue levels. Overall, 58% of hospitals reported uncompensated care amounts less than or equal to 5% of total revenues. Overall, 21% of the hospitals reported aggregate community benefit expenditures less than 2% of total revenues; 47% reported aggregate community benefit expenditures less than 5% of revenues. Critical access hospitals and the smallest hospitals generally reported higher percentages of hospitals below these levels. High population hospitals and the largest hospitals generally reported lower percentages of hospitals below these levels.

5. Revenues vs. expenses. Reported excess revenues (total revenues less expenses) varied across the demographics. Overall, when data was aggregated for all hospitals, revenues exceeded expenses by 5%. This percentage was 3% for the smallest hospitals and increased with revenue size. Among the community types, critical access hospitals reported the smallest percentage, and other rural hospitals reported the largest percentage. Overall, 21% of the hospitals reported a deficit (total expenses greater than total revenues). The percentage of hospitals reporting deficits varied by community type and revenue size.

6. Community income and insurance coverage levels. The study did not find a correlation between community benefit expenditure levels and per capita income levels of the area surrounding the hospital. The study did, however, observe that

community benefit expenditure levels generally increased as uninsured rates of the area surrounding the hospital increased.

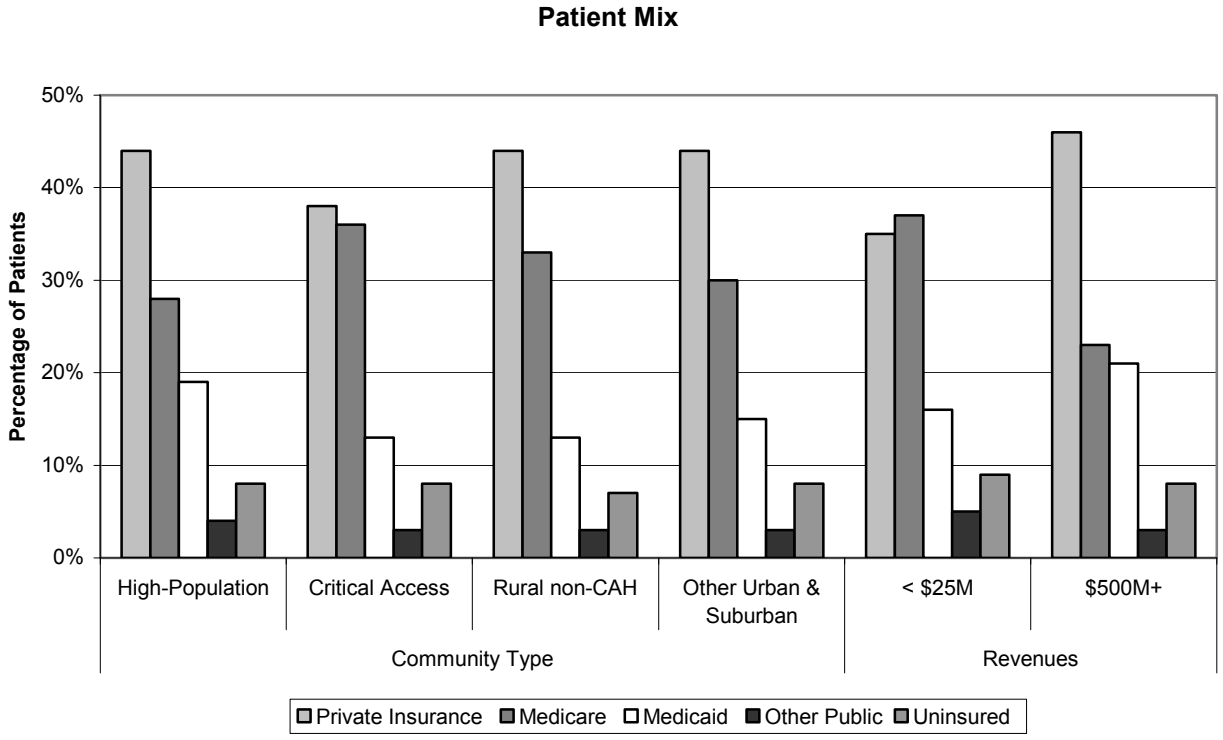
7. Compensation practices. Nearly all hospitals in the study reported complying with key elements of the rebuttable presumption procedure available to establish compensation of certain executives and disqualified persons. Based on traditional risk analysis and the compensation examinations of 20 hospitals, the study found widespread compliance with the Section 4958 excess benefit transaction rules. Although many reported compensation amounts appeared to be high, nearly all amounts reviewed in these examinations were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation.

C. Summary of Demographics and Community Benefit

The following summarizes key demographic or community benefit measures.

1. Patient Mix

The reported patient mix of the overall group of hospitals showed that the highest percentage of patients was private insurance patients (43%), followed by Medicare (31%), Medicaid (15%), uninsured (8%), and other public programs (3%).

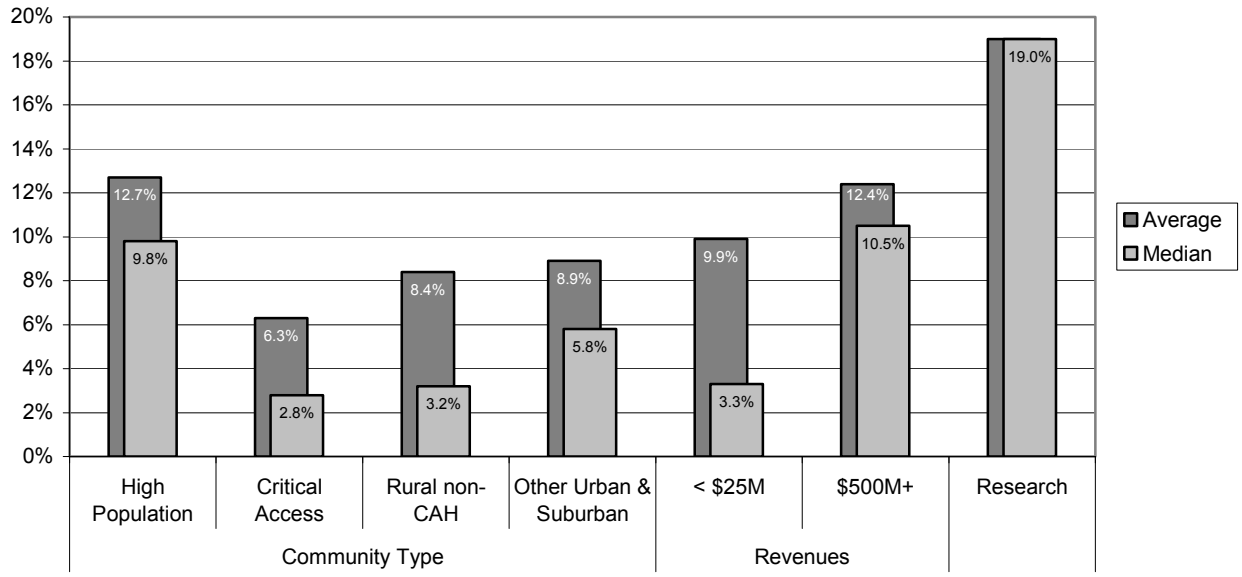


Critical access hospitals and the smallest hospitals reported the lowest percentage of private insurance patients and the highest percentage of Medicare patients. High population hospitals and the largest hospitals had the highest percentage of Medicaid patients.

2. Community Benefit Expenditures (percentages of total revenues)

The overall average and median percentages of total revenues reported as spent on aggregate community benefit expenditures were 9% and 6%, respectively. These percentages varied across community type and revenue size. Aggregate community benefit expenditures were not evenly distributed by the hospitals in the study, but were concentrated in a relatively small number of hospitals. 9% of the hospitals reported 60% of the aggregate community benefit expenditures; 19% of the hospitals reported 78% of the aggregate community benefit expenditures.

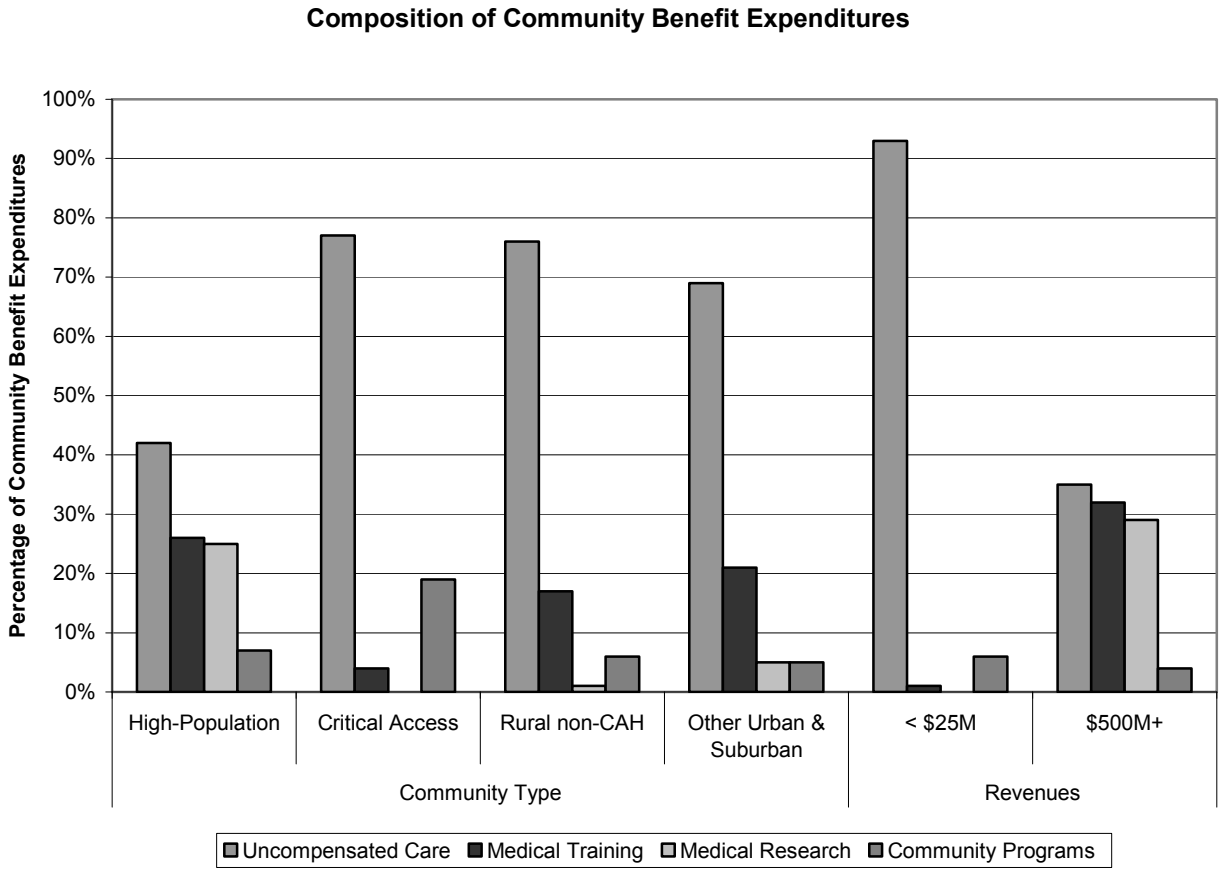
Community Benefit Expenditures as Percentage of Total Revenues



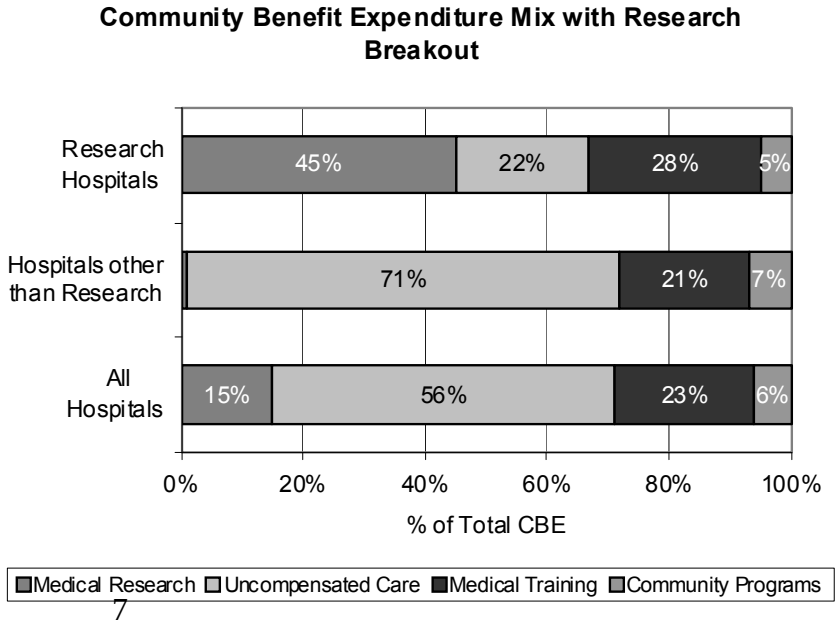
Among community types, the percentages were lowest for critical access hospitals and highest for high population hospitals. The percentages of total revenues generally increased with revenue size. The highest reported average and median percentages were by the group of 15 hospitals that reported nearly all of the medical research expenditures (referred to as "research hospitals" for this section).

3. Community Benefit Expenditures Mix (uncompensated care, medical education and training, medical research, community programs)

Uncompensated care was the largest component of reported community benefit for each community type and revenue size category, but the composition varied across the demographics.



Uncompensated care as a percentage of overall community benefit expenditures was greatest for CAHs, other rural hospitals, and the smallest hospitals. Significant variations were observed in reported expenditures for medical education and training expenditures and medical research across the community types. Both medical education and training and medical research expenditures as a percentage of overall community benefit expenditures increased with revenue size. The inclusion of bad debt and various shortfalls impacted the uncompensated care levels reported. Overall, and for each community type and revenue size, greater percentages of hospitals reported including bad debt and self pay shortfalls in uncompensated care than any other types of shortfalls.



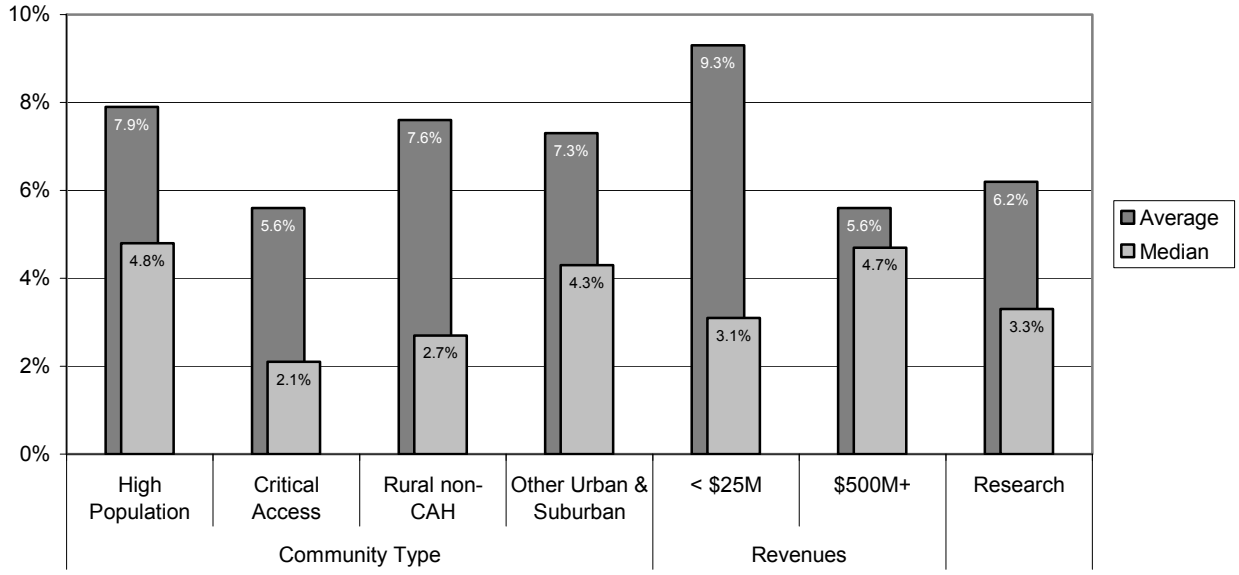
The community benefit mix changed materially when

the group of 15 hospitals that reported nearly all of the medical research expenditures was removed. The figure above shows the mix for the overall group, the group of 15 hospitals reporting nearly all of the medical research expenditures, and the overall group without the 15 hospitals.

4. Uncompensated Care (percentages of total revenues)

The average and median percentages of total revenues reported as spent on uncompensated care were 7% and 4%, respectively. Uncompensated care expenditures were not evenly distributed among the hospitals in the study, but were concentrated in a relatively small number of hospitals. 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures; 26% of the hospitals reported 82% of the aggregate uncompensated care expenditures.

Uncompensated Care as Percentage of Total Revenues



Critical access hospitals reported the lowest percentages and high population hospitals reported the highest percentages among the community types. The group of smallest hospitals reported the highest average percentage, but the lowest median percentage, among the revenue size groups.

5. Comparison of Reported Uncompensated Care and Community Benefit Expenditures against Specified Percentage of Revenue Levels

The figure below displays the percentage of hospitals with reported community benefit and uncompensated care expenditures at or less than specified percentage of revenue levels.

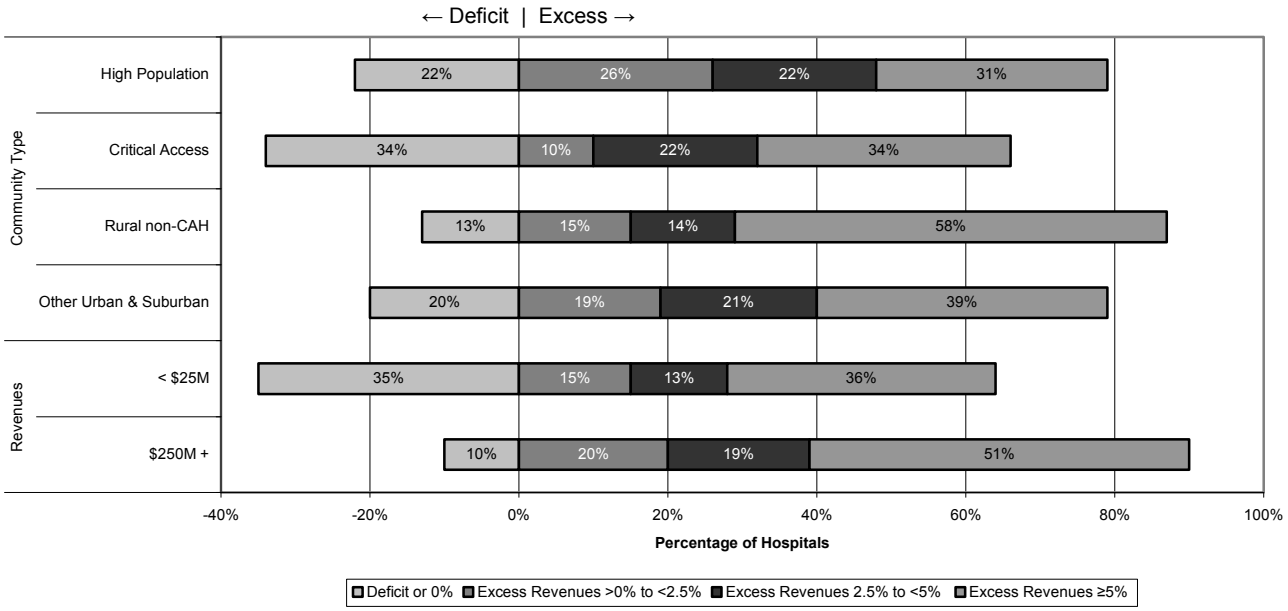
Demographic:	% of hospitals with community benefit expenditures <2% of revenues	% of hospitals with community benefit expenditures <5% of revenues	% of hospitals with uncompensated care expenditures ≤3% of revenues	% of hospitals with uncompensated care expenditures ≤5% of revenues
High population	11%	32%	33%	52%
CAH	39%	61%	59%	67%
Rural – non CAH	31%	57%	52%	65%
Other urban and suburban	17%	46%	39%	55%
Under $25 million	34%	60%	49%	60%
$25 million to under $100 million	30%	56%	49%	61%
$100 million to under $250 million	12%	42%	37%	55%
$250 million to under $500 million	*	*	34%	49%
Over $500 million	*	*	33%	60%
Overall	21%	47%	43%	58%

* The two largest revenue sizes were combined to prevent potential identification of respondent hospitals. In the combined group ($250 million and over), the percentage of hospitals with community benefit expenditures less than 2% of revenues is 5%, and less than 5% of revenues is 27%.

6. Revenues vs. Expenses

79% of the hospitals reported excess revenues (revenues exceeding expenses as reported on the Form 990), and 21% reported that total expenses exceeded total revenues (i.e., reported a deficit). The percentage of hospitals that reported revenue deficits decreased as revenue size increased, and varied across the community types. CAHs and the smallest hospitals had the highest percentage of hospitals reporting a deficit.

Distribution of Hospitals by Excess Revenue



Overall, excess revenues expressed as a percentage of total revenues was 4.6% and increased with revenue size. Among community types, critical access hospitals reported the lowest percentage (4%), and other rural hospitals reported the highest percentage (6%).

D. Executive Compensation

The study's questionnaire asked various questions regarding each hospital's compensation practices. These involved reporting compensation amounts for the hospital's officers, directors, trustees, and key employees, as well as information regarding certain policies and practices used to establish compensation for such persons. In addition, the study involved the examination of 20 organizations regarding their executive compensation practices.

In general, the hospitals reported widespread compliance with key indicators of sound compensation practices, including use of formal written compensation policies, use of comparability data, approval in advance by persons without a conflict of interest, and setting compensation within the range of comparability data. This pattern was reported consistently across the community types and revenue size categories, and was confirmed in the examinations of the 20 hospitals.

The average and median compensation amounts paid to the top management official as reported on the questionnaire were $490,000 and $377,000, respectively. Compensation amounts varied across demographics, but generally increased as the hospital's revenue size increased. Generally, rural hospitals (CAH and non-CAH) paid lower compensation than did urban and suburban hospitals (high population and other urban and suburban).

For the 20 hospital compensation examinations, the average and median compensation amounts paid to the top management official were $1.4 million and $1.3 million, respectively. Because the examined hospitals were selected on the basis of higher reported compensation amounts, a disparity between the overall group and the examined hospitals was expected.